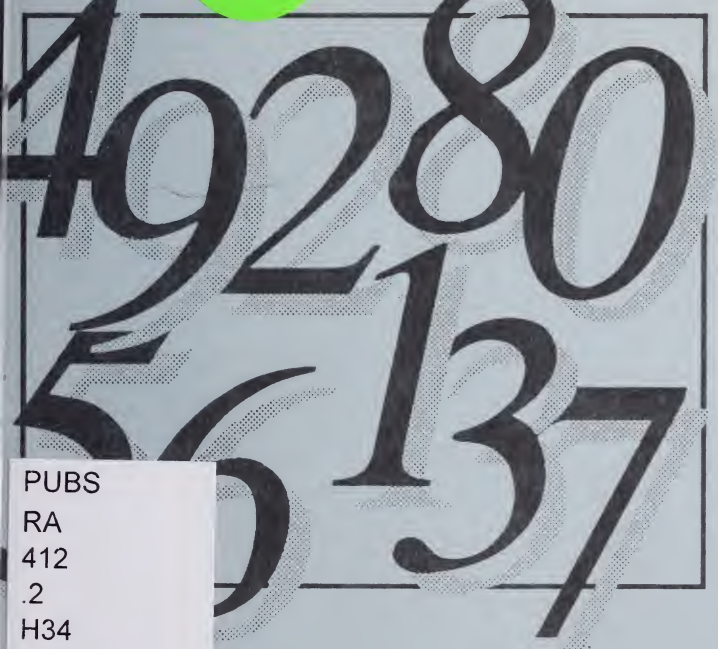
1995 HCFA Statistics



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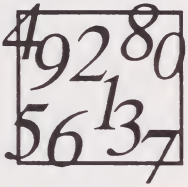
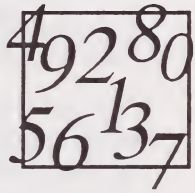
Preface



This reference booklet provides significant summary information about health expenditures and Health Care Financing Administration (HCFA) programs. The information presented was the most current available at the time of publication. Significant time lags may occur between the end of a data year and aggregation of data for that year.

The data are organized as follows:

Highlights



Growth in HCFA programs and health expenditures

Populations

- Persons enrolled for Medicare coverage increased from 19.5 million in 1967 to a projected 37.6 million in 1995, a 93 percent increase.

- Medicaid recipients increased from about 10 million in calendar year 1967 to a projected 36.2 million in fiscal year 1995, an increase of 262 percent. Dependent children rose from 9.8 million in 1985 to 17.6 million in 1995, an increase of 80 percent.

Providers/Suppliers

- The number of inpatient hospital facilities decreased from 6,707 in 1975 to 6,414 in 1995. Between 1975 and 1980, the number of hospitals classified as short-stay gradually increased from 6,084 to 6,111. However, by January 1995, the number decreased to 5,292. Total inpatient hospital beds have dropped from 51.5 beds per 1,000 enrolled in 1975 to 29.4 in 1995, a decrease of 43 percent.

- The total number of Medicare certified beds in short-stay hospitals showed a steady increase from less than 800,000 at the beginning of the program and peaked at 1,025,000 in 1984-86. Since that time, the number has dropped to slightly more than 943,000.

- The number of psychiatric hospitals grew to about 400 by 1976, where it remained until the start of the prospective payment system (PPS) in 1983. Since that time, the number has grown to 709.

- At the beginning of 1995, PPS covered 5,265 or 82 percent of all hospitals.

- The number of skilled nursing facilities (SNFs) increased rapidly during the 1960s, decreased during the first half of the 1970s, and has been increasing ever since, reaching 12,584 by the beginning of 1995, an increase of 10.0 percent since the beginning of 1994.

- After peaking in December 1970, the number of home health agencies (HHAs) remained stable during most of the decade. The number of HHAs accelerated with the passage of the Omnibus Budget Reconciliation Act of 1980, which permitted the certification of proprietary HHAs in States not having licensure laws. By December 1986, there were almost 6,000 participating facilities. Between 1994 and 1995, the number of HHAs has grown from 7,000 to 7,827, an increase of 11.8 percent.

- Since the Clinical Laboratory Improvement Act of 1988, (provision effective late 1991) the number and percentage of providers covered increased dramatically. Between 1991 and 1995, these grew from 90,126 to 159,8035, or an increase of 77.3 percent.

Expenditures

- Total HCFA program outlays were $57.9 billion in 1980, 9.8 percent of the Federal budget . By 1994, total HCFA program outlays were $226.8 billion, 15.5 percent of the Federal budget.

- Medicare skilled nursing facility benefit payments have increased from $5.0 billion in 1993 to $7.1 billion in 1994, an increase of 56.8 percent.

- Medicare home health agency benefit payments have grown significantly from $9.5 billion in FY 1993 to $12.0 billion in FY 1994, an increase of 26.3 percent.

- Medicare hospice expenditures have grown significantly, from $958 million in FY 1993 to $1.4 billion in 1994, an increase of nearly 46.1 percent.

Utilization of Medicare and Medicaid services

- Over 61 million persons are projected to receive services paid by Medicare or Medicaid in fiscal year 1995. Medicaid recipients as a percent of the total civilian population have risen from 10.2 percent in 1990 to 13.5 percent in 1994.

- Nearly one out of five, or more than 12.0 million persons, will use inpatient hospital services covered by Medicare or Medicaid during 1995. The ratio of Medicare aged users of any type of covered service has grown from 367 per 1,000 enrolled in 1967 to 826 per 1,000 enrolled in 1993.

- Nearly 71 percent of Medicare enrollees and Medicaid recipients, or about 49 million persons, are projected to receive reimbursable physician services during 1995.

- About 32 million persons are projected to receive reimbursable outpatient hospital services under Medicare or Medicaid during 1995.

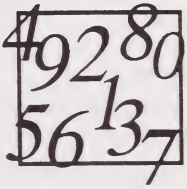
- Over 1.0 million persons are projected to receive care in SNFs covered by Medicare during 1995. This represents a 16.2 percent increase since last year.

- Over 1.7 million persons are projected to receive care in nursing facilities, which include SNFs and all other intermediate care facilities other than mentally retarded, covered by Medicaid during 1995.

- Over 25 million persons are projected to receive prescribed drugs under Medicaid during 1995.

Populations

Information about persons covered by Medicare or Medicaid



For Medicare, statistics are based on persons enrolled in hospital insurance (HI) and supplementary medical insurance (SMI) for coverage. For Medicaid, recipient counts are used as a surrogate of persons eligible for coverage, as well as for persons utilizing services. Statistics are available by major program categories, by demographic and geographic variables, and as proportions of the U.S. population. Utilization data organized by persons served may be found in the Utilization section.

Table 1
Medicare enrollment/trends

	Total persons	Aged persons	Disabled persons
July		In millions	
1966	19.1	19.1	—
1970	20.5	20.5	—
1975	25.0	22.8	2.2
1980	28.5	25.5	3.0
1985	31.1	28.2	2.9
1990	34.2	30.9	3.3
1991	34.9	31.5	3.4
1992	35.6	32.0	3.6
1993	36.3	32.4	3.8
1994	36.7	32.6	4.1
1995[1]	37.6	33.1	4.5
1996[1]	38.3	33.6	4.7

[1]Data for 1966-1994 are as of July. Data for 1995 -1996 represent ever enrolled estimates.

NOTE: Numbers may not add to totals because of rounding.

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Health Care Information Services and the Office of the Actuary: Data from the Office of Medicare and Medicaid Cost Estimates.

Table 2
Medicare enrollment/coverage

	HI and/or SMI	HI	SMI	HI and SMI	HI only	SMI only
			In millions			
All persons	37.1	36.7	35.3	34.9	1.8	0.4
Aged persons	32.8	32.5	31.5	31.1	1.4	0.4
Disabled persons	4.3	4.3	3.8	3.8	0.4	([1])

[1]Number less than 500.

NOTE: Data as of March 1995.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Health Care Information Services.

Table 3
Medicare enrollment/demographics

	Total	Male	Female
		In thousands	
All persons	37,700	16,117	21,583
Aged	33,553	13,618	19,935
65-74 years	17,280	7,736	9,544
75-84 years	11,770	4,603	7,168
85 years and over	4,503	1,280	3,224
Disabled	4,147	2,498	1,648
Under 45 years	1,447	904	543
45-54 years	1,130	684	446
55-64 years	1,569	910	659
White	32,485	13,840	18,644
Black	3,358	1,432	1,926
All Other	1,452	690	762
Native American	38	20	18
Asian/Pacific	190	84	106
Hispanic	452	224	228
Other	773	363	410
Unknown Race	405	154	251

NOTES: Data as of March 1995. Numbers may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Health Care Information Services.

Table 4
Medicare enrollment/end stage renal disease trends

	HI and/or SMI	HI	SMI
July			
1980	66,741	66,254	64,896
1982	76,117	75,707	73,705
1984	97,780	97,080	94,620
1986	120,060	118,946	116,093
1988	141,300	139,958	135,687
1990	172,078	170,629	163,708
1992	207,356	205,918	196,994
1993	225,859	224,317	214,687
1994	234,771	233,133	224,667

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Health Care Information Services.

Table 5
Medicare enrollment/end stage renal disease demographics

	Number of enrollees
All persons	234,771
Age	
Under 25 years	7,726
25-44 years	51,775
45-64 years	83,898
65 years and over	91,372
Sex	
Male	126,441
Female	108,360
Race	
White	134,614
Other	86,165
Unknown	13,992

NOTE: Data as of July 1994.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Health Care Information Services.

Table 6
Medicare/health maintenance organizations (HMOs)

	Number of Plans	Enrollees in thousands
Total prepaid	242	3,115
HCPPs/GPPPs[1]	56	582
Total HMOs	186	2,532
TEFRA risk	154	2,340
Cost basis	29	176
Demonstrations	3	17

[1]Health care prepayment plans/group practice prepayment plans.

NOTES: Data as of January 1995. Numbers may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Office of Prepaid Health Care Operations and Oversight.

Table 7
Medicare enrollment/HCFA region

	Resident[1] population	Medicare[2] enrollees	Enrollees as percent of population
	In thousands		
All regions	[3]260,341	[3]35,914	13.8
Boston	13,270	2,007	15.1
New York	26,073	3,753	14.4
Philadelphia	26,708	3,923	14.7
Atlanta	47,632	7,161	15.0
Chicago	47,751	6,734	14.1
Dallas	30,058	3,671	12.2
Kansas City	12,284	1,913	15.6
Denver	8,255	989	12.0
San Francisco	38,142	4,435	11.6
Seattle	10,168	1,302	12.8

[1]The population estimates shown here are based on the July 1, 1994 resident population.
[2]Medicare enrollment data are as of July 1, 1994.
[3]Excludes persons in Puerto Rico, Guam, Virgin Islands, outlying areas, those with unknown State of residence, and those living in foreign countries.

NOTE: Numbers may not add to totals because of rounding.

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of health Care Information Services. U.S. Bureau of the Census, Population Division, Population Estimates Branch.

Table 8
Aged population/projected

	1995	2000	2025	2050	2075	2100
			In millions			
65 years and over	34.2	35.4	60.8	74.1	83.7	89.9
75 years and over	15.1	16.8	25.1	39.3	45.9	50.6
85 years and over	3.8	4.4	6.3	14.7	16.9	20.1

SOURCE: Social Security Administration, Office of Programs: Data from the Office of the Actuary.

Table 9
Life expectancy at age 65/trends

Year	Male	Female
	In years	
1965	12.9	16.3
1980	14.0	18.4
1985	14.4	18.6
1990	15.0	19.0
1991	15.0	19.0
1992	15.5	19.3
1993	15.2	19.1
1994[1]	15.2	19.0
1995[1]	15.3	19.1
1996[1]	15.3	19.2
1997[1]	15.4	19.2

[1]Estimated.

SOURCE: Social Security Administration, Office of Programs: Data from the Office of the Actuary.

Table 10
Elderly persons living below poverty level/trends

Year	Persons in millions	Percent of Total Elderly
1966	5.1	28.5
1970	4.8	24.6
1980	3.9	15.7
1985	3.5	12.6
1990	3.7	12.2
1991	3.8	12.4
1992	3.9	12.9
1993	3.8	12.2

NOTES: Beginning in 1983, income estimates used for determining poverty level were based on improved measurement of interest income. Income estimates beginning 1987 are based on revised methodology.

SOURCE: U.S. Department of Commerce, Bureau of the Census.

Table 11
Medicaid recipients/trends

	Fiscal year					
	1975	1980	1985	1994[1]	1995[1]	1996[1]
	In millions					
Total[2]	22.0	21.6	21.8	35.1	36.2	37.7
Age 65 years and over	3.6	3.4	3.1	4.1	4.2	4.4
Blind	0.1	0.1	0.1	0.1	0.1	0.1
Disabled	2.4	2.8	2.9	5.4	5.9	6.2
Dependent children under 21 years of age	9.6	9.3	9.8	17.3	17.6	18.3
Adults in families with dependent children	4.5	4.9	5.5	7.6	7.8	8.1
Other Title XIX	1.8	1.5	1.2	0.6	0.6	0.6

[1]Estimated.

[2]Eligibility categories may not add to totals as some recipients are classified in more than one category during the year and due to the exclusion of unknowns.

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Medicaid Statistics and the Office of the Actuary: Data from the Office of Medicare and Medicaid Cost Estimates.

Table 12
Medicaid recipients/State buy-ins for Medicare

	1975[1]	1980[1]	1993[2]	1994[2]
	In thousands			
All buy-ins	2,846	2,954	4,303	4,558
Aged	2,483	2,449	3,102	3,213
Disabled	363	504	1,200	1,345
	Percent of SMI enrollees			
All buy-ins	12.0	10.9	12.4	13.0
Aged	11.4	10.0	10.0	10.2
Disabled	18.7	18.9	34.6	36.2

[1]Recipients for whom the State paid Medicare supplementary medical insurance (SMI) premiums for the month of July. Number of SMI enrollees includes those with unknown State of residence, but excludes those living in foreign countries.

[2]Beneficiaries in person years for whom the State paid the Medicare SMI premium during the year. Percent calculated using July enrollment.

NOTE: Numbers may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Health Care Information Systems..

Table 13
Medicaid recipients/demographics

	Fiscal year 1994 Medicaid recipients	Percent distribution
	In millions	
Total recipients	35.1	100.0
Age	35.1	100.0
Under 6 years	8.8	25.0
6-20 years	9.4	26.8
21-64 years	10.9	31.0
65 years and over	4.3	12.3
Unknown	1.7	4.9
Sex	35.1	100.0
Male	12.6	35.9
Female	20.6	58.9
Unknown	1.8	5.2
Race	35.1	100.0
White	15.9	45.3
Other	15.8	45.0
Unknown	3.4	9.7

NOTE: Numbers may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy; Data from the Division of Health Care Information Services.

Table 14
Medicaid recipients/HCFA region

	Resident[1] population	Medicaid[2] recipients	Recipients as percent of population
	In thousands		
All regions	[3]260,341	35,056	13.5
Boston	13,270	1,539	11.6
New York	26,073	4,641	17.8
Philadelphia	26,708	2,882	10.8
Atlanta	47,632	6,940	14.6
Chicago	47,751	5,655	11.8
Dallas	30,058	4,291	14.3
Kansas City	12,284	1,387	11.3
Denver	8,255	728	8.8
San Francisco	38,142	5,734	15.0
Seattle	10,168	1,259	12.4

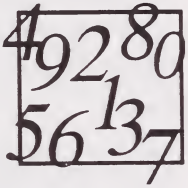
[1]The population estimates shown are based on the July 1, 1994 population.
[2]Medicaid recipient data are as of fiscal year 1994.
[3]Excludes persons in outlying areas, those with unknown State of residence and those living in foreign countries.

NOTE: Numbers may not add to totals because of rounding.

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy; Data from the Division of Health Care Information Services. U.S. Department of Commerce, Bureau of the Census.

Providers/Suppliers

Information about institutions, agencies, or professionals who provide health care services and individuals or organizations who furnish health care equipment or supplies



These data are distributed by major provider/supplier categories, by geographic region, and by type of program participation. Utilization data organized by type of provider/supplier may be found in the Utilization section.

Table 15
Inpatient hospitals/trends

	1975	1980	1994	1995
Total hospitals	6,707	6,780	6,473	6,414
Beds in thousands	1,132	1,152	1,094	1,074
Beds per 1,000 enrollees	51.5	46.9	30.5	29.4
Short-stay	6,084	6,111	5,378	5,292
Beds in thousands	884	988	955	943
Beds per 1,000 enrollees	40.2	40.2	26.6	25.8
Psychiatric	358	408	735	709
Beds in thousands	207	136	100	89
Beds per 1,000 enrollees	9.4	5.5	2.8	2.4
Other long-stay	265	261	360	413
Beds in thousands	42	29	40	43
Beds per 1,000 enrollees	1.9	1.2	1.1	1.2

NOTES: Facility data as of January 1, excluding Christian science. Rates based on number of HI enrollees as of July 1, 1994, excluding foreign countries.

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Health Care Information Services. Office of Research and Demonstration: Data from the Division of Program Studies.

Table 16
Medicare assigned claims/HCFA region

	Net assignment rates		
	1980	1993	1994
All regions	51.5	89.2	92.1
Boston	67.4	95.9	96.9
New York	51.8	89.0	91.6
Philadelphia	61.6	92.1	93.9
Atlanta	52.3	91.0	93.5
Chicago	47.6	88.3	92.2
Dallas	50.3	86.4	90.3
Kansas City	40.4	83.3	87.5
Denver	39.5	77.9	84.2
San Francisco	53.2	90.7	93.5
Seattle	31.3	76.1	83.0

NOTE: Calendar year data.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Reports and Information Management.

Table 17
Hospitals and units/status under the prospective payment system (PPS)[1]

Total hospitals	6,418
Hospitals under PPS	5,265
Hospitals receiving special consideration:	886
Regional referral centers	167
Sole community hospitals	719
Medicare dependent small rural hospitals[2]	0
Non-PPS hospitals	1,153
Categorically exempt:	1,086
Psychiatric	707
All other non short-stay	379
Short-stay hospitals in waiver States or demonstrations[3]	54
Short-stay hospitals in outlying areas	4
Cancer hospitals	9
Total excluded units	2,233
Psychiatric	1,402
Rehabilitation	831

[1] PPS is a reimbursement system whereby Medicare payment for inpatient operating costs is made at a predetermined specific rate for each discharge rather than on a reasonable-cost basis. All discharges are classified according to a list of diagnosis-related groups.
[2]Provision ended12/94.
[3]Short-stay hospitals in demonstration project lost waiver 12/94.

NOTE: Data as of March 1995.

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Health Care Information Services; Bureau of Policy Development: Division of Hospital Payment Policy; and the Health Standards and Quality Bureau: Data from the Division of Systems Management and Data Analysis.

Table 18
Long-term facilities/HCFA region

	Title XVIII and XVIII/XIX SNFs[1]	Nursing Facilities	IMRs[2]
All regions	12,584	4,183	7,253
Boston	996	186	275
New York	888	79	1,173
Philadelphia	1,208	213	469
Atlanta	2,247	315	681
Chicago	2,690	1,064	2,199
Dallas	1,240	1,173	1,403
Kansas City	842	830	186
Denver	524	124	107
San Francisco	1,461	147	674
Seattle	488	52	86

[1]Skilled nursing facilities.
[2]Institutions for mentally retarded.

NOTE: Data as of January 1995.

SOURCE: Health Care Financing Administration, Health Standards and Quality Bureau, Office of Survey and Certification. Data from the Division of System Management and Data Analysis.

Table 19
Other Medicare providers and suppliers/trends

	1975	1980	1994	1995
Home health agencies	2,254	2,858	7,000	7,827
Medicare laboratories	2,994	3,448	165,155[1]	159,803[1]
End stage renal disease facilities	—	975	2,462	2,655
Outpatient physical therapy	115	386	1,686	2,024
Portable X-ray	131	210	505	537
Rural health clinics	—	359	1,213	1,679
Comprehensive outpatient rehabilitation facilities	—	—	231	256
Ambulatory surgical centers	—	—	1,664	1,907
Hospices	—	—	1,445	1,726

[1]Includes providers newly covered under the Clinical Laboratory Improvement (CLIA) Amendment of 1988, provision effective 1992 .

NOTES: 1995 Data as of January. 1995 Medicare laboratory data as of May.

SOURCE: Health Care Financing Administration, Health Standards and Quality Bureau, Office of Survey and Certification. Data from the Division of System Management and Data Analysis.

Table 20
Selected facilities/type of control

	Short-stay hospitals	Skilled nursing facilities	Home health agencies
Total facilities	5,292	12,584	7,827
		Percent of total	
Nonprofit	57.8	27.5	34.6
Proprietary	13.5	66.7	48.2
Government	28.7	5.8	17.2

NOTES: Data as of January 1995. Facilities certified for Medicare are deemed to meet Medicaid standards.

SOURCES: Health Care Financing Administration, Office of Research and Demonstrations: Data from the Division of Program Studies. Health Standards Quality Bureau, Office of Survey and Certification: Data from the Division of System Management and Data Analysis.

Table 21
Periodic interim payment (PIP) facilities/trends

	1980	1985	1992	1993	1994
Hospitals					
Number of PIP	2,276	3,242	1,293	1,265	1,253
Percent of total participating	33.8	48.3	20.0	19.7	19.6
Skilled nursing facilities					
Number of PIP	203	224	975	1,131	1,265
Percent of total participating	3.9	3.4	9.1	9.9	10.2
Home health agencies					
Number of PIP	481	931	1,369	1,334	1,465
Percent of total participating	16.0	16.0	21.8	19.1	18.5

NOTES: Data from 1985 to date are as of September; 1980 data are as of December. The Omnibus Budget Reconciliation Act of 1986 eliminated PIP for many inpatient hospitals.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Reports and Information Management.

Table 22
Physicians active in patient care/trends

	1980		1985		1995	
	Number	Percent	Number	Percent	Number	Percent
Physicians	[1]361,915	100.0	[1]431,527	100.0	[2]693,129	100.0
Specialties						
Medical	105,049	29.0	132,519	30.7	115,695	16.7
Surgical	103,312	28.5	118,955	27.6	172,398	24.9
Other	96,871	26.8	117,109	27.1	214,118	30.9
General Pract.	56,683	15.7	62,944	14.6	[3]190,918	27.5

[1]Non-federal physicians only.
[2]Includes physicians, doctors of osteopathy (DOs), and limited licensed practitioners (LLPs).
[3]Specialties include general practice, family practice and internal medicine.

SOURCES: For 1980 and 1985: American Medical Association: *Physician Characteristics and Distribution in the U.S.* Chicago: 1992. 1995 data are dervived from the HCFA Unique Physician Indentification Number (UPIN) Directory.

Table 23
Physicians/HCFA region

	Physicians active in patient care	Physicians per 100,000 population
All regions	[1]693,129	266
Boston	46,958	354
New York	92,096	353
Philadelphia	77,875	292
Atlanta	112,273	236
Chicago	122,127	256
Dallas	64,256	214
Kansas City	29,654	241
Denver	18,961	230
San Francisco	104,209	273
Seattle	24,719	243

[1]Excludes physicians in foreign countries.

NOTES: Physicians as of January 1995. Civilian population as of July 1, 1994.

SOURCE: HCFA Unique Physician Identification Number (UPIN) Directory.

Table 24
Inpatient hospitals/HCFA region

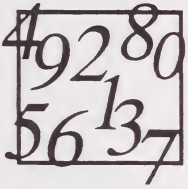
	Short-stay hospitals	Beds per 1,000 enrollees	Long-stay facilities	Beds per 1,000 enrollees
All regions	5,292	25.8	1,122	3.6
Boston	218	21.0	80	6.1
New York	368	27.1	75	4.6
Philadelphia	434	25.7	128	5.1
Atlanta	1,008	29.9	205	3.1
Chicago	947	32.3	152	3.1
Dallas	781	33.6	237	5.3
Kansas City	467	33.4	55	3.1
Denver	292	29.8	43	4.2
San Francisco	557	26.4	126	2.7
Seattle	218	21.6	21	2.4

NOTES: Data as of January 1995. Rates based on number of hospital insurance enrollees as of July 1, 1994.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Health Care Information Services.

Expenditures

Information about spending for health care services by Medicare, Medicaid, and in the Nation as a whole



Health care spending at the aggregate levels is distributed by source of funds, types of service, geographic area, and broad beneficiary or eligibility categories. Direct out-of-pocket, other private, and non-HCFA-related expenditures are also covered in this section. Expenditures on a per-unit-of-service level are covered in the Utilization section.

Table 25
HCFA and total Federal disbursements

	Fiscal year 1994 in billions
Gross domestic product (current dollars)	$6,633.6
Total Federal budget[1]	1,460.9
Percent of gross domestic product	22.0
Department of Health and Human Services[1,2]	624.7
Percent of Federal budget	42.8
HCFA budget	
Medicare benefit payments	159.3
Medicaid medical assistance payments	78.8
HCFA program management	2.1
State and local administration/training	3.3
Other administrative expenses	0.8
Peer review organizations	0.2
Total (unadjusted)	244.5
Offsetting and proprietary receipts	-17.7
Total net of offsetting and proprietary receipts[1]	226.8
Percent of Federal budget	15.5

[1]Includes off-budget entities, net of offsetting receipts.
[2]Includes the Social Security Administration.

NOTE: Numbers may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Office of Financial and Human Resources: Data from the Division of Budget.

Table 26
Program outlays/trends

	Total	Medicare[1]	Medicaid[2]
		In billions	
Fiscal year			
1980	$60.8	$35.0	$25.8
1990	182.2	109.7	72.5
1994	305.7	162.5	143.2
1995[3]	332.5	177.4	155.1

[1]Medicaid amounts are gross outlays for benefits and administration.
[2]Medicaid amounts include both the Federal and State share of benefit payments and administrative costs.
[2]Estimated.

SOURCE: Health Care Financing Administration, Office of Financial and Human Resources: Data from the Division of Budget.

Table 27
Benefit outlays by program

	1967	1968	1994	1995[1]
Annually		Amounts in billions		
HCFA program outlays	$5.1	$8.4	$297	$323
Federal Outlays	NA	6.7	238	259
Medicare	3.2	5.1	159	174
HI	2.5	3.7	101	110
SMI	0.7	1.4	58	64
Medicaid[2]	1.9	3.3	138	149
Federal share	NA	1.6	79	85
Monthly	In millions		In billions	
HCFA program outlays	$423	$702	$25	$27
Federal Outlays	NA	561	20	22
Medicare	264	427	13	15
HI	209	311	8	9
SMI	055	116	5	5
Medicaid	158	275	12	12
Federal share	NA	133	7	7
Hourly	In thousands		In millions	
HCFA program outlays	$579	$962	$34	$37
Federal Outlays	NA	768	27	30
Medicare	362	585	18	20
HI	286	426	12	13
SMI	076	159	7	7
Medicaid	217	377	16	17
Federal share	NA	183	9	10
Minutely		In thousands		
HCFA program outlays	$10	$16	$566	$615
Federal Outlays	NA	13	453	493
Medicare	6	10	303	331
HI	5	7	193	210
SMI	1	3	110	122
Medicaid	4	6	263	283
Federal share	NA	3	150	161

[1]Estimated.

[2]Does not include administrative costs incurred by the States.

NOTES: Fiscal year data. Numbers may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Office of Financial and Human Resources: Data from the Division of Budget.

Table 28
Program benefit payments/HCFA region

	Medicare[1]	Medicaid	
		Computable[2]	Net adjusted[3]
		In millions	
All regions	$159,345	$137,604	$78,844
Boston	9,380	9,602	4,978
New York	18,564	26,478	13,279
Philadelphia	18,160	13,314	7,318
Atlanta	32,773	20,972	13,617
Chicago	26,525	22,875	13,064
Dallas	16,183	15,138	10,377
Kansas City	7,053	5,151	3,158
Denver	3,550	2,658	1,717
San Francisco	22,780	17,140	8,866
Seattle	4,378	4,276	2,470

[1]Distribution by region is estimated. Excludes residence unknown and residents of foreign countries.
[2]Total medical assistance payments computable for Federal funding.
[3]Net adjusted Federal share. Does not include administrative expenditures.

NOTES: Data as of fiscal year 1994. Numbers may not add to totals because of rounding.

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Health Care Information Services; Office of Financial and Human Resources: Data from the Division of Budget; and the Medicaid Bureau: Data from the Division of Financial Management.

Table 29
Medicare/trust fund projections

	Fiscal year		
	1994	1995	1996[1]
	In billions		
HI benefit payments[2]	$101.4	$110.2	$121.0
Aged	89.7	97.0	106.1
Disabled	11.7	13.1	14.8
SMI benefit payments	58.0	64.0	73.6
Aged	50.2	55.8	63.9
Disabled	7.8	8.2	9.7

[1]Estimated.
[2]Excludes peer review organization (PRO) expenditures.

NOTE: Numbers may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Office of Financial and Human Resources: Data from the Division of Budget.

Table 30
Medicare/type of benefit

	Fiscal year 1994 benefit payments in millions[1]	Percent distribution
Total HI[2]	$101,350	100.0
Inpatient hospital	80,866	79.8
Skilled nursing facility	7,116	7.0
Home health agency	12,005	11.8
Hospice	1,363	1.3
Total SMI	57,997	100.0
Physician/other suppliers	37,283	64.3
Outpatient hospital	13,155	22.7
Home health agency	137	0.2
Group practice prepayment	5,464	9.4
Independent laboratory	1,958	3.4

[1]Includes the effect of regulatory items and recent legislation but not proposed law.
[2]Excludes peer review organization (PRO) expenditures.

NOTES: Numbers may not add to totals because of rounding. Benefits by type of service are estimated and subject to change.

SOURCE: Health Care Financing Administration, Office of Financial and Human Resources: Data from the Division of Budget.

Table 31
Medicaid/type of service

	Fiscal year	
	1993	1994
	In billions	
Total vendor payments	$101.7	$107.9
	Percent of total	
Inpatient services	27.4	26.1
General hospitals	25.3	24.2
Mental hospitals	2.1	1.9
Nursing facility services[1]	25.0	24.9
Intermediate care facility (MR) services[2]	8.7	7.7
Physician services	6.8	6.7
Dental services	0.9	0.9
Other practitioner services	0.9	1.0
Outpatient hospital services	6.1	5.9
Clinic services	3.4	3.5
Laboratory and radiological services	1.1	1.1
Home health services	5.5	6.5
Prescribed drugs	7.8	8.2
Family planning services	0.5	0.5
Early and periodic screening	0.8	0.9
Rural health clinic services	0.2	0.2
Other care	4.7	6.0

[1]Nursing facilities include: SNFs and all other categories for Intermediate Care Facilities (ICF), other than "MR".
[2]"MR" indicates mentally retarded.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy, Office of Health Care Information Systems.

Table 32
Medicaid/payments by eligibility status

	Fiscal year 1994 vendor payments	Percent distribution
	In millions	
Total	$107,982	100.0
Age 65 years and over	33,384	30.9
Blind/disabled	42,231	39.1
Dependent children under 21 years of age	17,306	16.0
Adults in families with dependent children	13,581	12.6
Other Title XIX	1,255	1.2

NOTE: Numbers may not add to totals due to the exclusion of unknowns and because of rounding.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Office of Health Care Information Systems.

Table 33
National health care/trends

	Calendar year		
	1965	1980	1993
National total in billions	$41.6	$251.1	$884.2
Percent of GDP[2]	5.9	9.3	13.9
Per capita amount	$204	$1,068	$3,299
Source of funds		Percent of total	
Private	75.3	58.1	56.1
Public	24.7	41.9	43.9
Federal	11.6	28.7	31.7
State/Local	13.2	13.3	12.1

NOTES: These data reflect Bureau of Economic Analysis Gross Domestic Product as of July 1994, and the Social Security Administration's revisions to the population as of July 1994. Totals do not necessarily equal the sum of rounded components.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

Table 34
National health care/type of expenditure

	National total in billions	Per capita amount	Private as a percent of total	Public
Total	$884.2	$3,299	56.1	43.9
Health services and supplies	855.2	3,191	56.6	43.4
Personal health care	782.5	2,920	56.9	43.1
Hospital care	326.6	1,218	44.0	56.0
Physicians' services	171.2	639	66.0	34.0
Nursing home care	69.6	260	50.5	49.5
Other personal care	215.1	803	77.8	22.2
Other services and supplies	72.7	271	53.4	46.6
Research and construction	29.0	108	41.7	58.3

NOTE: Data are as of calendar year 1993.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

Table 35
Personal health care/payment source

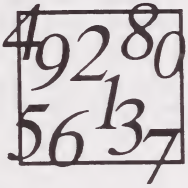
	Calendar year		
	1970	1980	1993
		In billions	
Total	$64.8	$220.1	$782.5
		Percent	
Total	100.0	100.0	100.0
Private	65.3	60.5	56.9
Out-of-pocket	39.1	27.8	20.1
Other private	26.1	32.6	36.8
Public	34.7	39.5	43.1
Federal	22.7	28.8	33.1
State and Local	12.0	10.7	10.0

NOTES: Excludes administrative expenses, research, construction, and other types of spending that are not directed at patient care. Totals do not necessarily equal the sum of rounded totals..

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Health Statistics.

Utilization

Information about the use of health care services



Utilization information is organized by persons receiving services and alternately by services rendered. Measures of health care usage include: persons served, units of service (e.g., discharges, days of care, etc.), and dimensions of the services rendered (e.g., average length of stay, charge per person or per unit of service). These utilization measures are aggregated by program coverage categories, provider characteristics, type of service, and demographic and geographic variables.

Table 36
Medicare/short-stay hospital utilization

	1990	1993	1994[1]
Discharges[2]			
Total in millions[3]	10.5	11.1	11.4
Rate per 1,000 enrollees	313	319	318
Days of care			
Total in millions	94	95	87
Rate per 1,000 enrollees	2,805	2,711	2,448
Average length of stay per discharge	9.0	8.5	7.6
Total charges per day	$1,060	$1,385	$1,684

[1]Data for 1994 should be considered preliminary.
[2]Includes admissions and transfers to excluded units within PPS hospitals.
[3]The population base excludes HI enrollees residing in foreign countries.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Health Care Information Services.

Table 37
Medicare long-term care/trends

	Skilled nursing facilities		Home health agencies	
	Persons served in thousands	Served per 1,000 enrollees	Persons served in thousands	Served per 1,000 enrollees
Calendar year				
1982	252	9	1,172	40
1985	315	10	1,576	51
1990	638	19	1,978	58
1991	670	19	2,255	65
1992	779	22	2,504	71
1993	908	25	2,867	80

[1]Increased utilization coincident with changes enacted under the Medicare Catastrophic Coverage Act of 1988.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Health Care Information Services.

Table 38
Medicare average length of stay/trends

	Fiscal year					
	1984	1990	1991	1992	1993	1994
All short-stay hospitals	9.1	9.0	8.7	8.5	8.1	7.6
PPS hospitals[1]	8.0	[2]8.9	8.7	8.5	8.1	7.3
Excluded units	18.0	19.5	18.7	18.0	17.2	15.9

[1]Bills for stays that overlap a hospital's transition into the Prospective Payment System (PPS) are aggregated and included in PPS. Average length of stay may differ from that based on that portion of stays actually covered by PPS.
[2]Includes pre-PPS experience, hospitals in waiver States, cancer hospitals, PPS excluded units, demonstration hospitals, and hospitals in outlying areas.

NOTES: Fiscal year data. Average length of stay is shown in days. For all Short-stay and PPS hospitals, 1984 data are based on a 20-percent sample of Medicare HI enrollees. Data for 1990 through 1994 are based on 100-percent MEDPAR. Data may differ from other sources or from the same source with a different update cycle.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Health Care Information Services.

Table 39
Medicare persons served/trends

	Calendar year				
	1967	1980	1985	1990	1993
Aged persons served per 1,000 enrollees					
HI and/or SMI	367	638	722	802	825
HI	203	221	219	209	216
SMI	365	652	739	832	856
Disabled persons served per 1,000 enrollees					
HI and/or SMI	—	594	669	734	751
HI	—	246	228	209	211
SMI	—	634	715	804	825

NOTES: Data for 1993 exclude beneficiaries in foreign countries. Persons served are those for whom Medicare Trust Fund payments were made. Based on July 1, enrollment. Rates may differ from estimates using risk-based enrollment.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Health Care Information Services.

Table 40
Medicare persons served/projections

	Fiscal year				
	1994	1995	1996	1997	1998
	In millions				
HI					
Aged					
Enrollees	32.2	32.4	32.7	33.0	33.2
Persons served	7.0	7.0	7.1	7.2	7.3
Disabled					
Enrollees	4.5	4.5	4.8	5.1	5.4
Persons served	0.9	0.9	1.0	1.1	1.1
SMI					
Aged					
Enrollees	31.7	31.7	32.1	32.3	32.5
Persons served	26.8	26.8	27.3	27.8	28.3
Disabled					
Enrollees	3.8	3.8	4.1	4.4	4.6
Persons served	3.1	3.1	3.4	3.6	3.9

NOTES: Enrollment represents actuarial estimates of average monthly enrollment during the fiscal year. Persons served represents actuarial estimates of beneficiaries projected to meet the Part A or Part deductible amount during the fiscal year.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicare and Medicaid Cost Estimates.

Table 41
Medicare persons served/HCFA region

	Aged persons served in thousands	Served per 1,000 enrollees	Disabled persons served in thousands	Served per 1,000 enrollees
All regions[1]	26,785	826	2,887	754
Boston	1,552	865	151	782
New York	3,064	824	326	706
Philadelphia	3,085	878	299	777
Atlanta	5,365	862	674	792
Chicago	5,186	865	524	756
Dallas	2,720	848	314	760
Kansas City	1,525	882	139	785
Denver	725	833	71	710
San Francisco	2,646	668	300	696
Seattle	905	779	89	730

[1]Excludes residents of foreign countries.

NOTES: Data as of calendar year 1993 for persons served under HI and/or SMI. Based on utilization for fee-for-service and excludes utilization under alternative payment systems such as health maintenance organizations. Numbers may not add to totals because of rounding.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Health Care Information Services.

Table 42
Medicare/end stage renal disease (ESRD)

	Calendar year	
	1993	1994
Total enrollees[2]	225,859	234,771
Dialysis patients[3]	171,479	186,822
Outpatient	140,680	153,674
Home	30,799	33,148
Transplants performed[4]	10,934	11,312
Living donor	2,631	2,738
Cadaveric donor	8,106	8,312
Living Unrelated	197	262
Average dialysis payment rate		
Hospital-based facilities	$130	$130
Freestanding facilities	$126	$126

[1]Preliminary.
[2]Medicare ESRD enrollees as of July 1.
[3]Includes Medicare and non-Medicare patients receiving dialysis as of December 31.
[4]Includes kidney transplants for Medicare and non-Medicare patients.

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of ProgramSystems and the Bureau of Policy Development: Data from the Division of Special Payment Programs.

Table 43
Medicaid/type of service

	Fiscal year 1994 Medicaid recipients
	In thousands
Total	35,056
Inpatient services	
General hospitals	5,867
Mental hospitals	85
Nursing facility services[1]	1,635
Intermediate care facility (MR) services[2]	159
Physician services	24,262
Dental services	6,350
Other practitioner services	5,411
Outpatient hospital services	16,563
Clinic services	5,259
Laboratory and radiological services	13,418
Home health services	1,376
Prescribed drugs	24,473
Family planning services	2,562
Early and periodic screening	6451
Rural health clinic services	946
Other care	9,955

[1]Nursing facilities include: SNFs and all categories of ICF, other than "MR".
[2]"MR" indicates mentally retarded.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Health Care Information Services.

Table 44
Medicaid/units of service

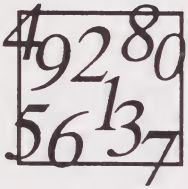
	Fiscal year 1994 units of service
	In thousands
General hospital	
Total discharges	5,644
Recipients discharged	3,913
Total days of care	32,152
Nursing facility	
Total days of care	398,424
Intermediate care facility/mentally retarded	
Total days of care	53,283

NOTES: Based on reporting States and the District of Columbia (Data are not reported for Arizona and Puerto Rico). Nursing facilities include: SNFs and all categories of ICF, other than MR.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Health Care Information Services.

Administrative/Operating

Information on activities and services related to oversight of the day-to-day operations of HCFA programs



Included are data on Medicare contractors, contractor activities and performance, HCFA and State agency administrative costs, quality control, and summaries of the operation of the Medicare trust funds.

Table 45
Medicare administrative expenses/trends

	Administrative expenses	
	Amount in millions	As a percent of benefit payments
HI Trust Fund		
1970	$149	3.1
1975	259	2.5
1980	497	2.1
1985	813	1.7
1990	774	1.2
1991	934	1.4
1992	1,191	1.5
1993	866	1.0
1994	1,235	1.2
SMI Trust Fund		
1970	217	11.0
1975	405	10.8
1980	593	5.8
1985	922	4.2
1990	1,524	3.7
1991	1,505	3.3
1992	1,661	3.4
1993	1,845	3.5
1994	1,718	3.0

NOTE: Fiscal year data.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicare and Medicaid Cost Estimates.

Table 46
Medicare/contractors

	Intermediaries	Carriers
Blue Cross/Blue Shield	40	20
Other	5	8

NOTES: Data as of January 1995. Reference to intermediaries as Part A has been dropped in recognition of the fact that intermediaries also service Part B institutional bills as well as Part A claims.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Acquisitions and Contracts.

Table 47
Medicare/appeals

	Intermediary reconsiderations	Carrier reviews
Number processed	47,129	4,376,355
Percent reversal rate[1]	40.3	76.1

[1]Excludes withdrawals and dismissals.

NOTE: Data for fiscal year 1994.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Reports and Analysis.

Table 48
Medicare/claims processing bottom line unit costs

	Unit cost per claim			
	1975	1980	1993	1994
Intermediaries[1]	$3.84	$2.96	$2.61	$1.51
Carriers[2]	2.90	2.33	1.60	$1.21

[1]Includes direct costs and overhead costs for bill payment, reconsiderations and hearings lines.
[2]Includes direct costs and overhead costs for the claims payment, reviews and hearings, and beneficiary/physician inquiries lines.

NOTE: Fiscal year data.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Financial Management.

Table 49
Medicare/claims processing

	Intermediaries	Carriers
Claims processed in millions	120.6	615.1
Total costs in millions	$502.3	$1,083.2
Claims processing costs in millions	$197.9	$615.0
Claims processing unit costs	$1.40	$ .89
Range		
High	$1.89	$1.16[1]
Low	$0.96	$ .76

[1]Excludes DMERCs

NOTE: Data for fiscal year 1994.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Financial Management.

Table 50
Medicare/claims received

	Claims received
Intermediary claims received in thousands	124,529
	Percent of total
Inpatient hospital	10.4
Outpatient hospital	44.4
Home health agency	13.3
Skilled nursing facility	2.2
Other	29.7
Carrier claims received in thousands	622,368
	Percent of total
Assigned	92.8
Unassigned	7.2

NOTE: Data for calendar year 1994.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Reports and Information Management.

Table 51
Medicare/charge reductions

	Assigned	Unassigned
Claims approved		
Number in millions	509.0	39.4
Percent reduced	[1]86.8	[1]86.0
Total covered charges		
Amount in millions	$84,559	$3,247
Percent reduced	42.4	16.2
Amount reduced per claim	$70.49	$13.43

NOTES: Data for calendar year 1994. As a result of report changes effective April 1, 1992, charge reductions include: reasonable charge, medical necessity and global fee/rebundling reductions.

[1]Figure may be slightly overstated due to the possibility of a claim being counted more than once because more than one type of reduction is applied.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Reports and Information Management.

Table 52
Medicaid/administration

	Fiscal year	
	1993	1994
	In thousands	
Total payments computable for Federal funding	$4,831,480	$6,183,420
Federal share of current expenditures:		
Family planning	12,840	13,381
Design, development or installation of MMIS[2]	30,493	44,247
Skilled professional medical personnel	128,833	140,748
Operation of an approved MMIS[2]	491,636	525,271
Other financial participation	1,976,299	2,626,051
Mechanized systems not approved under MMIS[2]	50,736	51,364
Total administration	2,690,837	3,401,062
Net adjusted Federal share[3]	2,682,140	3,064,493

[1]Source: Form HCFA-64.10, Expenditures for State and Local Administration for the Medical Assistance Program (net expenditure reported). FY 1994 data are preliminary.

[2]Medicaid Management Information System.

[3]Includes Federal share of net expenditures reported on the HCFA-64 plus HCFA adjustments.

SOURCE: Health Care Financing Administration, Medicaid Bureau: Data from the Division of Financial Management.

Table 53
Quality control/Medicare Part B carriers

	Average carrier error rate				
	1977	1985	1990[1]	1993[2]	1994
Occurrence [3]	8.7	6.4	6.1	3.2	1.9
Assigned	8.3	5.7	—	—	—
Unassigned	9.2	7.7	—	—	—
High	—	—	8.7	—	—
Medium	—	—	8.0	—	—
Low	—	—	5.5	—	—
EMC	—	—	—	2.1	1.4
Paper	—	—	—	4.8	3.5
Payment/deductible [4]	1.9	1.8	1.2	0.6	0.4
Assigned	1.8	1.7	—	—	—
Unassigned	2.0	1.8	—	—	—
High	—	—	1.1	—	—
Medium	—	—	1.4	—	—
Low	—	—	1.2	—	—
EMC	—	—	—	0.4	0.3
Paper	—	—	—	0.8	0.8

[1]As of July 1, 1989, under the revised Part B Quality Assurance System, the assigned and unassigned divisions were eliminated. The sample was divided into three groups using the amount of submitted charges (high, medium, and low). High-medium-low were calculated only between 1990 and 1991.
[2]As of January 1, 1992, HCFA began calculating error rates for electronic (EMC) and hard copy (paper) claims.
[3]Claims processing errors per 100 line items.
[4]Dollar error per $100 of submitted charges without nonreview penalty.

NOTE: Calendar year data.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Quality Programs.

Table 54
Quality control/Medicaid

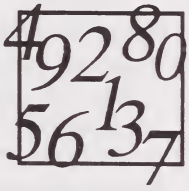
	Eligibility national average error rate[1] in percent of dollars
Fiscal year	
1985	2.7
1986	2.5
1987	2.3
1988	2.2
1989	2.0
1990	1.9
1991	1.9
1992	1.9
1993	2.0
1994[2]	2.0

[1]Excludes Supplemental Security Income determinations.
[2]Preliminary.

SOURCE: Health Care Financing Administration, Medicaid Bureau: Data from the Division of Program Performance.

Reference

Selected reference material including cost-sharing features of the Medicare program, program financing, and Medicaid Federal medical assistance percentages



Program financing

Medicare/source of income

Hospital Insurance trust fund:
1. Payroll taxes*
2. Transfers from railroad retirement account
3. General revenue for
   a. uninsured persons
   b. military wage credits
4. Premiums from voluntary enrollees
5. Interest on investments

*Contribution rate	1994	1995	1996
		Percent	
Employees and employers, each	1.45	1.45	1.45
Self-employed	2.90	2.90	2.90
Maximum taxable amount (CY 1995)			None[1]

Supplementary Medical Insurance trust fund:
1. Premiums paid by or on behalf of enrollees
2. General revenue
3. Interest on investments

Medicaid/financing
1. Federal contributions (ranging from 50 to 79 percent for fiscal year 1995)
2. State contributions (ranging from 21 to 50 percent for fiscal year 1995)

[1]The Omnibus Reconciliation Act of 1993 eliminated the Annual Maximum Taxable Earnings amounts for 1994 and later. For these years, the contribution rate is applied to all earnings in covered employment.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of Medicare and Medicaid Cost Estimates.

Medicare deductible and coinsurance amounts

Part A (effective date)	**Amount**
Inpatient hospital deductible (1/1/95)	$716/benefit period
Regular coinsurance days (1/1/95)	$179/day for 61st thru 90th day
Lifetime reserve days (1/1/95)	$358/day (60 nonrenewable days)
SNF coinsurance days (1/1/95)	$89.50/day for 21st thru 100th day
Blood deductible	first 3 pints/benefit period
Voluntary hospital insurance premium (1/1/95)	$261/month $183/month if have at least 30 quarters of coverage.
Limitations:	
Inpatient psychiatric hospital days	190 nonrenewable days
Part B (effective date)	**Amount**
Deductible (1/1/91)[1]	$100 in reasonable charges/year
Blood deductible	first 3 pints/calendar year
Coinsurance[1]	20 percent of allowed charges
Premium (1/1/95)	$46.10/month
Limitations:	
Outpatient treatment for mental illness	No limitations
Licensed physical therapist's services in home or office (1/1/91)	$600 (80% of maximum annual program payment of $750)

[1]The Part B deductible and coinsurance applies to most services. Items and/or services not subject to either the deductible or coinsurance are clinical diagnostic lab tests subject to a fee schedule, home health services, items and services furnished in connection to obtaining a second or third opinion, influenza vaccine and its administration, and pneumococcal vaccine and its administration. In addition, Federally qualified health center services are not subject to the deductible but are subject to the coinsurance.

SOURCE: Health Care Financing Administration, Office of Legislation and Policy: Data from the Divisions of Medicare Part A and Medicare Part B Analysis.

Geographical jurisdictions of HCFA regional offices and Federal medical assistance percentages (FMAP) fiscal year 1994

I.	Boston	FMAP
	Connecticut	50
	Maine	62
	Massachusetts	50
	New Hampshire	50
	Rhode Island	54
	Vermont	60
III.	**Philadelphia**	
	Delaware	50
	District of Columbia	50
	Maryland	50
	Pennsylvania	55
	Virginia	50
	West Virginia	76
V.	**Chicago**	
	Illinois	50
	Indiana	63
	Michigan	56
	Minnesota	55
	Ohio	61
	Wisconsin	60
VII.	**Kansas City**	
	Iowa	63
	Kansas	60
	Missouri	61
	Nebraska	62
IX.	**San Francisco**	
	Arizona	66
	California	50
	Hawaii	50
	Nevada	50
	American Samoa	50
	Guam	50
	N. Mariana Islands	50
	Mexico	—

II.	New York	FMAP
	New Jersey	50
	New York	50
	Puerto Rico	50
	Virgin Islands	50
	Canada	—
IV.	**Atlanta**	
	Alabama	71
	Florida	55
	Georgia	62
	Kentucky	71
	Mississippi	79
	North Carolina	65
	South Carolina	71
	Tennessee	67
VI.	**Dallas**	
	Arkansas	74
	Louisiana	73
	New Mexico	74
	Oklahoma	70
	Texas	64
VIII.	**Denver**	
	Colorado	54
	Montana	71
	North Dakota	71
	South Dakota	70
	Utah	74
	Wyoming	66
X.	**Seattle**	
	Alaska	50
	Idaho	71
	Oregon	62
	Washington	54

SOURCE: Health Care Financing Administration, Medicaid Bureau: Data from the Division of Financial Management.

☆ U. S. Government Printing Office: 1995 - 397-841 (40018)

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Bureau of Data Management and Strategy
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